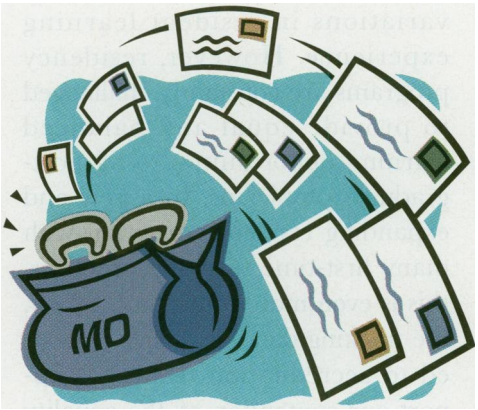
LETTERS • CORRESPONDANCE

Tracking programs waste of time



I was amazed and amused to read an evaluation of a computer tracking program for resident and patient encounters in Sudbury, Ont.[1] I was interested to read that Brian Rowe, Dale Ryan, and John Mulloy found that the Sudbury residents were able to enter regular, reliable, and valid data into the computer-based system in Sudbury.

The main argument for tracking is to validate these northern residencies, presumably in comparison to their southern counterparts. These programs, however, do not need to justify their existence. Northern Ontario family medicine residents see more or less the same patient populations that are seen in other areas of Ontario, economic and demographic features being essentially similar in both the north and the south. In fact, it might be that there is a more intense patient contact in acute care settings for northern residents who do not have to wait in line to be involved with critically ill patients, as would be the case in a more tiered system in the south. At any rate, it would be ludicrous to suggest that all residents should have similar patient encounter profiles during their 2-year residencies. All residents will have different exposures, and time and experience will generally correct for these inadequacies after graduation.

If you are going to enforce tracking in northern programs, then you should do the same in all medical programs in Ontario. Finally, even if these data were used by the residents themselves to improve their learning experience, it would have some value. However, most of these data go into the great computer bank of information, handy for people like Brian Rowe who like to play with data, but unavailable to the residents who enter the data in the first place.

The real issue here is that residents in these northern programs are being subjugated as secretaries at a significant time investment away from more important learning experiences, such as reading around patient encounters.

We are stuck in an era of data production, and as it has been said by others, data do not equate to real knowledge. In the case of the tracking program, the whole thing is so useless that it makes me, as my father often says, weak just to think about it.

— Ken Thacker, MD
Atikokan, Ont

Reference

1. Rowe BH, Ryan DT, Mulloy JV. Evaluation of a computer tracking program for resident-patient encounters. *Can Fam Physician* 1995;41:2113-20.

Response

We are dismayed by the frustration and anger Dr Thacker's letter expressed. To what extent this reflects the current medical-political climate in Ontario or this ex-resident's overall learning experience is unclear. We have only peripheral knowledge of the FMN:NWO tracking program, but clearly many unresolved issues appear to linger between Thacker and his program. We cannot and should not attempt to address these disputes. However, we can comment on his unfortunate misconceptions regarding encounter tracking in general. We note that he raises no methodological issues with respect to the research presented in the recent articles.[1,2]

First, Thacker incorrectly assumes that the main reason for the tracking program is "to validate these northern residencies, presumably in comparison to their southern counterparts." We strongly believe northern programs are valid sources of primary care training, and they do not require the tracking information to prove that. The primary use for the tracking program is as a multilevel evaluation tool for examining resident experience. Over time, the Northeastern Ontario Family Medicine (NOFM) tracking data have been used in diverse ways. Moreover, tracking is not a new program evaluation tool nor restricted in its use to evaluating northern learners.[1,2]

Second, evidence suggests that northern and rural programs offer

← FOR PRESCRIBING INFORMATION SEE PAGE 759

considerably different learning experiences from more traditional programs. Clearly, even within our training program we have found variations in resident learning experience. However, residency programs are constantly challenged to provide equal and balanced learning opportunities to all postgraduate physicians. In a new and expanding residency program with many first-time teaching practices, this is even more important. So far, the tracking data have been provided to accreditation teams to support our contention of the equality of resident learning opportunity and experience. Tracking data that are reliable and valid also assist the decision-making process regarding training practice selection and adjustments to the more formal didactic academic content within the program. We attempt to base decisions on the "evidence," and judging from his correspondence, Thacker cannot make the same claim.

We are concerned that Thacker underestimates, or is at least unfamiliar with, the responsibility assumed by all residency programs to critically evaluate the experience they provide. While not all programs are currently tracking encounters, we are aware of a growing interest in this concept from other centres. These tools are important sources of information that can direct and assist programs in improving the learning experience.

In addition, Thacker implies that the tracking data are unavailable to residents and others. Again, we cannot comment on policies of other programs. However, in providing tracking data feedback to our own residents, we have found them using these data in support of applications to hospitals and to reinforce applications for further training. The NOFM Program Director has used the tracking data to assist his decisions on changes to the program. Finally, these data are now being used to improve rotation objectives and select sites for additional training. We feel these are important and justified reasons for the collection of data that generally consumes less than 15 minutes of resident time per day. Tracking data entry is an even more attractive option when compared with certain traditional service obligations of residents in more established urban programs.

Finally, several times Thacker implies certain deficiencies among NOFM residents. We can assure him that we are proud of the contributions of our residents to the training program, including their integral involvement in the iterative improvement of the tracking program. While not every resident is supportive, they have been neither passive nor subjugated; most have put aside self-interest for the improvement of the training program for themselves and their colleagues.

We are anxious to promote discussion regarding encounter tracking, and we look forward to further debates on this issue. It is our strong belief that tracking data have made important contributions to the success of our northern program, and we are confident they will continue to do so.

— Brian H. Rowe, MD, CCFP(EM)
— John Mulloy, MD, MCFP(EM)
Sudbury, Ont

References

1. Mulloy JV, Leuschen M, Rowe BH. A computerized tracking program for resident clinical encounters. *Can Fam Physician* 1995;41:1742-51.

FOR PRESCRIBING INFORMATION SEE PAGE 772 ➔

2. Rowe BH, Ryan D, Mulloy JV. Compliance, validity and reliability of computer tracking program for resident patient encounters. *Can Fam Physician* 1995;41:2113-20.

Safety of medications in lactation cessation

Dr Livingstone's article[1] in the January issue seems to advocate the use of bromocriptine for managing lactation suppression. The 1996 *Compendium of Pharmaceuticals and Specialties*[2] does not list lactation suppression as an approved indication.

I would welcome clarification on the role and safety of use of this and other medications for lactation cessation.

— Eoghan O'Shea, MD, CCFP
Orleans, Ont

References

1. Livingstone V. Too much of a good thing. Maternal and infant hyperlactation syndromes. *Can Fam Physician* 1996;42:89-99.
2. Canadian Pharmaceutical Association. *Compendium of Pharmaceuticals and Specialties*. 31st ed. Ottawa: Canadian Pharmaceutical Association, 1996.

Response

Health Canada has recently withdrawn its approval for the use of bromocriptine as a lactation suppressant due to potential adverse effects, including postural hypotension, dizziness, and in some rare situations (1 in 100 000) hypertension, visual disturbances, myocardial infarctions, seizures, and strokes. The casual relationship of these events to the drug is uncertain. Bromocriptine is still approved for managing galactorrhea due to prolactin-secreting pituitary tumours because the benefits outweigh the risks.

In my article, I do not advocate the use of bromocriptine in the routine management of lactation suppression, but in my opinion, there are a few clinical situations when suppression of lactation is medically indicated. Sudden cessation of breastfeeding in the face of mastitis and breast abscess is contraindicated, because it might result in further complications. If it is the mother's informed choice to wean abruptly, then lactation suppression using bromocriptine might be indicated.

— Verity Livingstone, MB, BS, IBCLC
Vancouver

Value of certification

It is always a pleasure to read articles by James McSherry,[1] and his comment on the diverse results of researching the value of family practice certification is no exception.

Certification has been hallowed in the College circles, and attempts have been made to prove the value of keeping medical students another year in the artificial atmosphere of the university teaching centre rather than in the more practical world of the community.[2]

The experience I gained in 1955 from my first year of practice as a junior assistant for Drs Hall and Giovando in Nanaimo, BC, was far above any theoretical substitute in a family practice unit.[3] Certification does provide jobs for those bureaucratically inclined. Sadly, excellent practitioners consume energy that might have been given to desperately needed clinical research in family medicine.

Family medicine will remain powerless and always at the bottom of the medical scratching order until we put more emphasis on research and less on examining ourselves and our charts. David Rogers, Professor of Medicine at Cornell University, pointed out that in medical school a "sacred feeling of responsibility" should be formed as an "internal compass" for later guiding.[4]

He emphasized that to later impose managerial controls on highly motivated people simply does not work. Using charts to audit family doctors is a popular trend today but Rethans et al[5] recently showed in Dutch general practice that it is invalid.

We need more original thinkers in family medicine to confront today's problems and fewer followers of the status quo.

— Michael Livingston, MD
Richmond, BC

References

1. McSherry J. If family medicine certification is the answer, what was the question? [editorial]. *Can Fam Physician* 1995;41:2060-5 (Eng), 2076-80 (Fr).
2. Livingston MCP, Bass S, Emery AW, Thomson TA, Vaughan GA, Wong WT. Six medical students in a community hospital. *Can Med Assoc J* 1973; 109:1013-6
3. Livingston M. *Family medicine: an inside look.* Richmond, BC: Orc Enterprises, 1980:26-34.
4. Rogers DE. On trust: a basic building block for healing doctor-patient interactions. *J R Soc Med* 1994;87(Suppl 22):2-5.
5. Rethans JJ, Martin E, Metsemakers J. To what extent do clinical notes by general practitioners reflect actual medical performance? A study using simulated patients. *Br J Gen Pract* 1994;44:153-6.

FOR PRESCRIBING INFORMATION SEE PAGE 772 ➔